Mayers Memorial Hospital District

Quality Committee
Meeting Agenda

June 10, 2020 12:00 pm
Zoom Meeting: Meeting Link
Call In: 1-669-900-9128 Meeting ID: 954 0365 7995

Attendees

Laura Beyer, Board Secretary
Jeanne Utterback, Director
Louis Ward, CEO
Jack Hathaway, Director of Quality

1	**CALL MEETING TO ORDER**		Chair Laura Beyer			**Approx. Time Allotted**
2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**					
3	**APPROVAL OF MINUTES**					
	3.1	Regular Meeting – May 13, 2020		Attachment A	**Action Item**	2 min.
4	**REPORTS: QUALITY FACILITIES: NO REPORTS**					
5	**REPORTS: QUALITY STAFF: NO REPORTS**					
6	**REPORTS: QUALITY PATIENT SERVICES: WRITTEN REPORTS SUBMITTED**					
	6.1	Emergency Department	JD Phipps		Report	5 min.
	6.2	Radiology	Alan Northington		Report	5 min.
	6.3	SNF	Diana Groendyke		Report	5 min.
	6.4	Acute	Theresa Overton		Report	5 min.
	6.4	Infection Control	Dawn Jacobson		Report	5 min.
	6.5	SNF Events/Survey	Candy Vculek		Report	5 min.
7	**REPORTS: QUALITY FINANCES: NO REPORTS**				Report	10 min.
8	**REPORTS: QUALITY EDUCATION**					
	8.1	REPORT		Jack Hathaway	Report	10 min.
9	**QUALITY PROGRAM REPORTING AND INITIATIVES**					
	9.1	Quality/Performance Improvement		Jack Hathaway	Report	10 min.
	9.2	Prime		Jack Hathaway	Report	10 min.
10	**NEW BUSINESS**					
	10.1	POLICIES				
11	**ADMINISTRATIVE REPORT**			Louis Ward	Report	10 min.

12	**OTHER INFORMATION/ANNOUNCEMENTS**			Information	5 min.
13	**ANNOUNCEMENT OF CLOSED SESSION**				
	13.1	**List of Credentials** **STAFF STATUS CHANGE** Tommy Saborido, MD – add Family Medicine/Move to Karuna Sharma, MD – Move to Inactive Steven Brown, CRNA – Move to Inactive **AHP REAPPOINTMENT** Ben Nuti, CRNA - Reappointment **MEDICAL STAFF REAPPOINTMENT** Robin Rasmussen, MD – Wound Care Todd Guthrie, MD – Orthopedic Surgery **MEDICAL STAFF APPOINTMENT** Gary Belaga, MD – Neurology – Telemedicine Andrew Lin, DO – Neurology - Telemedicine Joseph Trudeau, MD – Radiology – Telemedicine Frederick Jones, MD – Radiology – Telemedicine Suzanne Aquino, MD – Radiology – Telemedicine David Bass, MD – Radiology – Telemedicine Dennis Burton, MD – Radiology – Telemedicine Peter Reuss, MD – Radiology – Telemedicine			
14	**RECONVENE OPEN SESSION** – Report closed session action			Information	
15	**ADJOURNMENT:** July 8, 2020 – Location TBD				

Public records which relate to any of the matters on this agenda (except Closed Session items), and which have been distributed to the members of the Board, are available for public inspection at the office of the Clerk to the Board of Directors, 43563 Highway 299 East, Fall River Mills CA 96028. This document and other Board of Directors documents are available online at www.mayersmemorial.com.

Chief Executive Officer
Louis Ward, MHA

Mayers Memorial Hospital District

Board of Directors
Quality Committee
Minutes

Full Remote Teleconference
May 13, 2020 @ 12:00 PM
Fully Remote Zoom Meeting

These minutes are not intended to be a verbatim transcription of the proceedings and discussions associated with the business of the board's agenda; rather, what follows is a summary of the order of business and general nature of testimony, deliberations and action taken.

1 **CALL MEETING TO ORDER:** Board Chair Laura Beyer called the meeting to order at 12:00 pm on the above date.

BOARD MEMBERS PRESENT:
Laura Beyer, Secretary
Jeanne Utterback, Director

ABSENT:

STAFF PRESENT:
Louis Ward, CEO
Candy Vculek, CNO
Keith Earnest, CCO
Jack Hathaway, DOQ
Dawn Jacobson
Jessica DeCoito, Board Clerk

2 **CALL FOR REQUEST FROM THE AUDIENCE – PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**
None

3 **APPROVAL OF MINUTES**

3.1 A motion/second carried; committee members accepted the minutes of April 8, 2020 ***Utterback, Hathaway*** **Beyer – Y**
Utterback – Y

4 **Quality Facilities Reports:**

4.1 **Marketing:** submitted written report. Kudos to Val on the keeping everyone up to date with Emergency Preparedness and messaging going out.

5 **Quality Staff Reports**

5.1 **Employee Health:** submitted written report. Annual physicals will start soon. Working out the details with HR while COVID-19 restrictions are still in place.

5.2 **Work Comp Quarterly:** submitted written report. Comparison to previous quarter and does COVID-19 restrictions have an effect on any employee related incidents. Louis to follow up with Libby and report back.

5.3 **Safety Quarterly:** submitted written report. No additional questions or comments.

5.4 **Staff Development:** Jessica to ask Brigid for full report outside of the PDF report template. And share report in minutes for May meeting. CNA training has been transitioned into a remote training. Onsite training will begin August for CNA's through Shasta College.

6 **Quality Patient Services**

6.1 **Volunteer Services:** submitted written report. During COVID-19 what is the volunteer situation? – Not many volunteers are being used especially with the Gift Shop and Thrift Shop being closed. But they have stepped up elsewhere with making masks, etc.

6.2 **Social Services:** submitted written report. We have seen some increased depression from residents but we are getting around to each resident to check in with them, in addition to keeping families up to date. Activities is stepping up to help moral as well.

6.3 **Activities:** submitted written report. There are employees from multiple departments helping out with Activities when their workloads aren't heavy because of COVID-19 restrictions. Candy to follow up with Sondra on reporting to Quality Committee with LEAN project.

6.4 **SNF Events/Survey:** Things are going well because we have a great team of employees. LEAN work is getting picked back up. We have some changes with CNA workflows to look at as well. CDPH is requiring a COVID-19 mitigation plan and our team is working on getting that completed and turned in.

6.5 **Infection Control:** went live for HSN for mandatory reporting. This includes daily reporting.

6.6 **Blood Transfusion:** submitted written report. Candy to follow up on Vitals Document (N) reporting from November 2019. Will report back once information is received.

7 **Quality Finances Reports: No Department Reports**

8 **Quality Program Reporting and Initiatives**

8.1 **Quality/Performance Improvement:** working through COVID-19. Telemedicine Quality work: process improvement through COVID-19 situation, because we are now able to get students into their tele-therapy program in the Physical Therapy building, and we do not have to collect data as we had before COVID-19. 100% of the students who started with tele-therapy have continued through this program even with COVID-19.

8.2 **PRIME:** submitted and received an initial approval. A deeper clinical review is now taking place. Some questions may come up but no issues are foreseen.

8.3 **Compliance Quarterly:** submitted report. Clarification on investigations.

8.4 **CMS Core Measures Quarterly Report:** submitted report. One measure has been dropped off on Imaging – OP-14, but the two other measures will still be looked at and relevant to our facility.

8.5 **5 Star Rating Monitoring Quarterly Report:** submitted written report. Issues have been remedied.

9 **NEW BUSINESS:** none

10 **ADMINISTRATIVE REPORT:** Happy Hospital Week (May 11 – May 15) – lots of fun activities while social distancing. COVID-19: Shasta Co. is in Phase 2. Alternative Care site has been dismantled but equipment is ready in case we do need it. Surgery is reopening on May 18th and expect to see surgeries beginning first part of June. Retail Pharmacy will reopen for in store visits, date TBD. Construction updates: Burney Clinic remodel has begun as of May 11th. Entrance and exit has been moved – Burney Fire and SEMSA has been altered and walked through in case of emergency. NHW – progress is coming along. Schedule reflects a July 7th completion date but crews are working all day and night. Administration & Finance building is coming along for completion around end of June. Laundry Facility restoration will begin shortly as well. Working on 1135 Waiver – allows us as hospitals and SNFs to not have to put in FLEX's for certain situations. Louis will represent Critical Access and Rural Hospitals in a National Press Conference on May 14th – will talk through MMHD's response to COVID-19.

11 **OTHER INFORMATION/ANNOUNCEMENTS:** None

12 **ADJOURNMENT: 1:33 pm** - Next Regular Meeting – June 10, 2020 (Fall River Mills)

Board Quality Report Template

Name: JD Phipps

Department: Emergency

Current report date to Board Quality:

6/10/20

Last report date to Board Quality:

11/6/19

Last Quality project reported:

Ongoing challenges for documentation of vitals (within 60min of discharge and Q2 hours) and pain reassessment.

Update on last Quality project reported:

Significant efforts including use of LEAN tools, individual coaching, and high focus to temporary staff. We have reached all three categories above goal of 90% for 1 of 3 required months. Staff have taken ownership of this process.

What successes have you seen based on the outcome of previous Quality projects?

Compliance with audit changes were slow but as mentioned above is being made.

What issues have come up in your department relating to Quality?

CDPH plan of corrections was developed following tag for EMTALA violation. Inspection (internal and CDPH) revealed suboptimal ED visit log with unassigned MD's and RN's, incomplete records of transfer paperwork, in appropriate use of "other" as chief complaint, improper Emergency Severity Index (ESI) rating which is a triage tool to identify patient severity at presentation.

PLAN: What plan was implemented to address those issues?

All staff were given formal ESI training via the Relias Learning platform and followed up with individual competency verification. Worked with admitting leadership to limit use of "other" during registration process. Provided education to nurses of need to change "other" to appropriate complaint whenever possible. Process verification of transfer packet duplication to manager to assure no records lost in HIM process.

DO: How did the implementation of that plan go?

Staff education of issues such as use of "other" was easy. Staff were unaware of the issue and simply discussing was enough. Training on ESI triage involved a long education session in Relias followed by testing but was completed in a timely manor.

STUDY: What kind of results did the implementation of the plan yield?

Monthly audits are ongoing until all aspects of the plan of correction have met target for 3 consecutive months. Occurrences of "unassigned" nurses and doctors in the ED log has already immediately corrected to meet goal. Retrospective audit of 3 months provided baseline for ESI scoring (60-65% accurate). Use of "other" has already met goal for 1 month.

ACT: What changes were made based on the results of the plan implementation?

Too soon to tell. Likely changes will need to occur in our transfer paperwork process. ESI training was added to new hire orientation as well as annual competency.

Is this a LEAN project? Yes ☐ No ■ **If YES, please attach the A3.**

Upcoming Quality Items:	**Quality Related Goals for the Department:**
Implementation of ultrasound guided PIV Implementation of Level 1 infuser	Working towards stroke certification and full implementation of sepsis plan

What Strategic Plan Objective does your project BEST align with? Choose only one.

☐ **Outstanding Facilities:** By 2025, we will open two rural health clinics, update the skilled nursing facility living space at the Fall River campus and have a resolution for aging facilities.

☐ **Outstanding Staff:** By 2025, we will be seen as an employer of choice in the area by providing and maintaining staff growth opportunities, flexible and safe working arrangements, and reducing the use of registry staff.

■ **Outstanding Patient Services:** By 2025, we will be a four-star long term care facility and meet all Hospital Consumer Assessment of Healthcare Providers (HCAHP) requirements. By 2025, we will be operating two rural health clinics.

☐ **Outstanding Finances:** By 2025, we will have in place and utilize financial tools to actively develop and forecast long term expenditures.

Data/Graphics supporting project outcomes:

Board Quality Report Template

Name:

Alan Northington

Department:

Imaging

Current report date to Board Quality:

Last report date to Board Quality:

Last Quality project reported:

Implementation of a new PACS (Picture Archiving Communication System) Ambra Health.

Update on last Quality project reported:

Implementation is complete however, with programs such as this, there are ongoing changes as we continue to customize the program to fit our specific needs. Example: We've identified the main hospitals we transfer to and have built destination nodes for those facilities, which allow us to send patient images and reports instantaneously. Failures are being identified much more quickly and the response of Ambra's service has allowed us to fix problems within minutes. Ambra has proven itself and is an exceptional platform for sharing images within seconds to anyone with an email address.

What successes have you seen based on the outcome of previous Quality projects?

Ambra needs to be mentioned here as well. It's strength is in it's ability to share images quickly. When we were still learning to use the platform, I was on the phone with an ER Physician at Shasta Regional who wanted to see images before he would accept a patient. The Shasta Regional ER was reluctant to provide an email address so I spoke with the ER Physician directly. He gave me his email address and he received all images and reports while I was still on the phone with him. Prior to Ambra, no outside facility had ever received images from Mayers more quickly and compared to CDs, there's no comparison.

What issues have come up in your department relating to Quality?

PLAN: What plan was implemented to address those issues?

DO: How did the implementation of that plan go? Implementation of both Ultrasound Transducer cleaning and raising the quality level of uniform patient histories, were smooth and timely. Implementation of the new Radiologist group has been an ongoing process of several months. Once the contract was executed, we began the interfacing process between Mayers' PACS and MD Imaging, which required a HL-7 Interface. The interface build continues and should be complete within two weeks of this writing.
STUDY: What kind of results did the implementation of the plan yield?
ACT: What changes were made based on the results of the plan implementation?

Upcoming Quality Items:	**Quality Related Goals for the Department:**

Data/Graphics supporting project outcomes:

Board Quality Report Template

Name: Diana Groendyke

Department: Skilled Nursing

Current report date to Board Quality:

June 10, 2020

Last report date to Board Quality:

Jan. 29, 2020

Last Quality project reported:

Value Stream Mapping for:
1. Admission Process
2. Raise Star Rating -- Focus on increasing RN Hours at Mayers-SNF
3. C.N.A. Daily Workflow

Update on last Quality project reported:

In order to raise our Star Rating we hired our own RN for Noc Shift at the Annex, Bob Parrish, RN. We also brought in RN Travelling Nurses to ensure we have RN's working every day of the year. -- days and nights. Also we have the P.A.'s on board now working with Dr. Watson. Together they all provide a much greater amount of Physician coverage for the Residents as well as allow for more Admissions to occur in a timely manner. These are 2 big factors that have increased our quality of care.

What successes have you seen based on the outcome of previous Quality projects?

Excellent RN care has been occurring on Noc Shift Burney Annex and at times in Fall River Mills Station 2 since last Summer 2019 due to our Quality Project to raise our Star Rating with additional RN coverage.
Also, our Residents have benefitted immensely due to the hiring of our two P.A.'s to work with Dr. Watson. They came early this year. We wanted to have more time for Admitting and also now have increased the Physician coverage for the Residents all the way around.

What issues have come up in your department relating to Quality?

Inadequate communication process was identified related to the ongoing changes in the Residents' daily needs. This results in a decrease in the quality of the Residents care and puts MMHD at risk for further CDPH tags.

Change of Shift Times are not 'Resident Centered'. Especially the Shift Changes by CNA's just as dinner is being served. Also that the Staff numbers drop down when everyone needs help to get ready for bed.

PLAN: What plan was implemented to address those issues?

Communication Process was reviewed and current process revised for communication of daily resident's needs so that Staff Members are better informed. In 'Point Click Care' (PCC) our Electronic Health Record Clinical Dashboard has been customized to include all relevant data for Nurses and CNA's to read in order to be up to date. All Nursing Staff were In-Serviced via Zoom on how to access, utilize and add to the communication on the Clinical Dashboard.

'CNA Daily Workflow' underwent 'Value Stream Assessing and Mapping' with representatives for all Stakeholders involved. This process caused very important changes that are occurring now: Activities Dept. was removed from serving beverages at each mealtime. Shift Change Times for all Nursing Staff is occurring that will be much more efficient at dinner and getting Residents ready for bed.

DO: How did the implementation of that plan go?

The Clinical Dashboard revision was in-serviced June 1, 2020. We are observing and encouraging the use of the Dashboard to ensure all needed knowledge about Residents are known to Nurses and CNA's.

The Shift Changes are getting ready to occurr on June 21, 2020.

STUDY: What kind of results did the implementation of the plan yield?

We are in the process of studying and observing what results both plans yield.

ACT: What changes were made based on the results of the plan implementation?

After studying the results we will make any needed changes to the plans based on our observations

Is this a LEAN project? Yes ■ No ☐ **If YES, please attach the A3.** ∈ CANDY.

Upcoming Quality Items:	**Quality Related Goals for the Department:**
Following strictly all CDPH & CDC 'Covid-19' regulations. No deficiencies in those areas.	Continue our RN coverage 7 days/week. Continue excellent Survey Results for SNF.

What Strategic Plan Objective does your project BEST align with? Choose only one.

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Data/Graphics supporting project outcomes:

June 4, 2020

Acute Quality-Scorecard Goals for Theresa Overton, DON

Goals:

1. Review and revise patient acuity system and level of system where assignments are done according to acuity so that skill will match the patient needs.
    - A new acuity system was adapted that is a good indicator for staffing which includes more patient care aspects. This allows for matching the skill of licensed personnel to patient needs. This form is completed by nursing staff each shift and is used in the staff assignment. (See attached "Staffing Acuity Indicator").

2. Develop and organize a standard approach for nursing communication with physicians, including specific tools and process that changes staff culture about when to contact the physician regarding patient care.
    - SBAR reporting to physician, supervisors, shift to shift ineffective regarding patients with change in condition and recognizing that change.
    - Developed SBAR for use by nurses to call physicians to report a Critical situation or Change in condition of the patient. This tool is to be used by nurses when communicating with physician, nursing supervisor and shift to shift. (See attached SBAR form").
    - Providers have noticed improved communication when being called with change of condition.

3. Develop and implement a standardized assessment and response process for nurses when managing patients who are having changes in their condition so that the result is that the nurse will recognize and manage immediately any change in condition.
    - Developed a Daily Management System (DMS) to establish that the licensed personnel will complete their patient assessments by 0800/2000. This time will be adjusted once the shift time changes on June 21st. This process was designed so that the nursing staff will have knowledge of their patient's condition in a timely manner within the start of their shift. In turn, they will recognize whether there are changes in the patient's condition to be reported to the nursing supervisor or the provider. A tracking form is logged daily for compliance. An Occurrence Tracker is also used for times when assessments are not completed to track "why". We can see if it is user noncompliance or computer issues. Staff is then counseled or assisted with issues that are out of their control. (See attached DMS and occurrence tracker form).
    - This has been a positive change and the staff has been compliant. The result is that nursing admin or the nursing supervisor can ask questions about their patients and the staff can answer without hesitation. There is better communication between the floor staff, supervisors and providers. This assessment process coincides with the SBAR and reporting of condition to the supervisors and providers.
    - This has been tested by giving patient scenarios and the licensed personnel recognizing changes and what they would do to manage the care of that patient.

MAYERS MEMORIAL HOSPITAL

Staffing Acuity Indicator

DATE_____ SHIFT_____

	Elimination	Day	Night
1	BR/Urinal without assist		
	Parents performing care		
2	Bed Pan/BSC 1-3x per shift		
	Catheter Care		
	BR/BSC/Bed pan with 1 staff		
	Bladder Training		
	Single enema		
3	BR/BSC/Bedpan with 2 staff		
	Bed Pan/BSC 4-6x per shift		
	Incontinent 1-2x per shift		
4	Bed Pan/BSC > 6x per shift		
	Bed Pan/BSC with >2 staff		
	Enemas until clear		
	Incontinent >2x per shift		

	Monitoring	Day	Night
1	VS/FSG/Neuro's q shift		
	Daily Bed Scale Weight		
2	VS/Neuro's q 3-4 hrs		
	FSG 2x		
	Intake & Output		
3	Chest Tube		
	Seizure Precautions		
	VS/Neuro's q 2 hrs		
	FSG 2-5x per shift		
	Continuous Bladder Irrigation		
	Fundal Checks		
4	FSG >5x a shift		
	VS/Neuro's q hour or greater		
	Infant bilirubin Protocol		

	Medications	Day	Night
1	PO Meds 1-2x per shift		
	Saline lock flush per shift		
2	Continuous IV fluids		
	Crush Meds		
	IV Push or Piggyback 1-2x/shift		
	PO Meds >2x per shift		
	Pediatric doses with 2 staff		
3	Meds via NG or G-Tube		
	IV Push or Piggyback >2x/shift		
	Continuous IV medication		
	TPN/PPN/Lipids		
	Blood/Blood product admin		
	PICC/Central line		
	COLUMN TOTAL:		

	Activity	Day	Night
1	Up Ad Lib		
	Active ROM		
	Chair without help		
2	Ambulate/chair with 1 staff		
	Dangle		
	Bedrest, turns without help		
3	Bedrest, turns with 1 staff		
	Ambulates with 2 staff		
	CPM/Passive ROM		
	Chair with 2 staff		
	Up with assist 2x		
4	Bedrest turns with >1 staff		
	Ambulates with > 1 staff		
	Hoyer lift		

	Teaching	Day	Night
1	Unable to educate		
	Plan of Daily Care		
	Routine Tests		
2	Family/Group		
	Pre/Post-op		
	Equipment		
	Medications (1-2)		
3	Discharge		
	Return Demo		
	Medication (more than 2)		
4	Disease Process		
	Post partum Care		

	Behavior /Psycho-Social	Day	Night
1	Unresponsive		
	Oriented/Cooperative		
2	Disoriented / redirectable		
	Communication Barrier		
	Sensory Deficit (blind/deaf)		
	Fall Precautions		
3	Restraint Use		
	Disoriented / Uncooperative		
4	Suicide precautions		
	Combative		
	Non-Compliant		
	Grief / Dying process		

	Nutrition	Day	Night
1	NPO/Ice Chips/Sips		
	Feeds Self		
2	Small Frequent Meals		
	Partial Assist		
	Calorie Count		
	Fluid Restriction		
3	Tube Feeding		
	Breast/ Bottle Feeding		
4	Total Assist		
	COLUMN TOTALS:		

	Hygiene		Day	Night
1	Self	Bed bath		
		Shower		
		Oral / Skin Care		
2	Assist	Partial or complete bed bath		
		Shower		
		Oral / Skin Care		
3	Complete	Partial or complete bed bath		
		Shower		
		Oral / Skin Care		
		Skin Care > 3x		
		Couplet Care		
		Catheter Care		

	Treatments/Procedures	Day	Night
1	Turn, Cough, Deep Breathe		
	O2 nasal		
	Incentive Spirometery		
	SCD's		
	K-Pad		
	Non-sterile dressing x1		
	Ted Hose R & R		
2	Suction 1-2 x		
	O2 via mask		
	Trach care		
	Catheter Insert		
	IV Insert		
	SCD's		
	Strain Urine		
	Immunocompromised		
	Isolation		
	Breathing tx 1-2x		
	Mist Tent		
3	Suction 3 times or more		
	MD assist at bedside		
	Wound care or packing		
	Sterile dressings		
	Telemetry monitoring		
4	Breathing tx >3x		
	Suction >4		
	Wound care with 2		
	Ostomy Care		
	Requires sitter		
	COLUMN TOTAL:		

		DAY	NIGHT
	GRAND TOTAL:		

Instructions: Mark the ONE item in each section that will give you the highest point value. Add the totals for each column and write the grand tota in the space provided. The point value gives you an acuity. Day shift calculates for Nights; Night shift calculates for Days.

KEY 1=0-7; 2=8-13 3=14-22 4=23+

DO NOT SCAN Not a part of the patient chart.

Patient Sticker

Attachment #1

SBAR report to physician about a ***Critical*** situation or ***Change*** in condition

S	**Situation** I am calling about_____(patient name and Location). Date Admitted_____. Admitting Diagnosis_____The patient's code status is: _____(code status) The **problem** I am calling about is: I have just assessed the patient personally: (have available: chart, IV fluids, allergies, meds, Labs/Results) Most recent vital signs: BP _____, Pulse _____, Respiration _____, Temp_____ I am concerned about the: Blood pressure --it is acutely trending ____up or ____down and signifies a change in condition. Pulse because it is <45 or >125 Respiration because it is < 10 or > 40. Temperature because it is less than 96 or over 104.
B	**Background** **The patient's mental status is** Alert and oriented to person place and time. Confused and cooperative or non-cooperative Agitated or combative Lethargic but conversant and able to swallow Stuporous and not talking clearly and possibly not able to swallow Comatose. Eyes closed. Not responding to stimulation. **The skin is:** Warm and dry Pale Mottled Diaphoretic Extremities are cold Extremities are warm. **Medications:** _____ **Allergies:**_____ **The patient ____is or ____is not on oxygen.** The patient has been on _____(l/min) or (%) oxygen for _____minutes. The oximeter is reading_____% The oximeter does not detect a good pulse and is giving erratic readings.
A	**Assessment** This is what I think the problem is_____(your suggestion) The problems seems to be cardiac infection neurologic respiratory I am not sure what the problem is but the patient is deteriorating. The patient seems to be unstable and may get worse, we need to do something!
R	**Recommendation** **I suggest or request that you** _____(say what you would like to see done) Transfer the patient to higher level of care Come to see the patient at this time. Talk to the patient or family about code status **Are there any new orders?:** I would recommend_____ **If a change in treatment is ordered, then ask:** How often do you want vital signs?_____ If the patient does not improve, when would you want us to call again? _____

Attachment #2

Goal: Patient Assessments Completed and Charted by 0800/2000

Date Range:

(Metric)

100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%

Day/Date	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N
	1	1	2	2	3	3	4	4	5	5	6	6	7	7	8	8	9	9	10	10	11	11	12	12	13	13	14	14	15	15	16	16	17	17	18	18	19	19	20	20	21	21	22	22	23	23	24	24	25	25	26	26	27	27	28	28	29	29	30	30	31	31
Assess# (Metric)																																																															
Total # Metric)																																																															

Attachment #3

Occurrence Tracker

Process:	Patient Assessment Completed and Charted by 0800/2000														
Start/End Dates: 8/1-31															
Count of Occurrences	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

Attachment #36